

STATE EMPLOYEES' LEAVE BANK REQUEST FORM
To Be Completed by the Agency of the Requesting Employee

NAME: _____ SOCIAL SECURITY #: _____

CLASSIFICATION: _____ EOD: _____

AGENCY: _____ AGENCY CODE: _____

AGENCY CONTACT PERSON: _____

PHONE NUMBER: _____ FAX NUMBER: _____

EMPLOYEE SIGNATURE: _____ DATE: _____

LAST DAY WORKED AS A RESULT OF CURRENT IMPAIRMENT: _____

HOURS REQUESTED: _____ EFFECTIVE DATE OF THIS REQUEST: _____

EMPLOYMENT RECORD – Applicable to Leave Bank Request (ONLY)

Has the employee been on a one day sick leave restriction within the last two calendar years?
_____ Yes _____ No If yes, when? _____

Has the employee received disciplinary action within the last year? _____ Yes _____ No

What was the last Overall Performance Evaluation rating? _____

SUPERVISOR SIGNATURE: _____ DATE: _____

SUPERVISOR RECOMMENDATION: _____ Approval _____ Disapproval

AGENCY SIGNATURE: _____

AGENCY RECOMMENDATION: _____ Approval _____ Disapproval

**CERTIFICATION BY TIMEKEEPER OR APPOINTING AUTHORITY OF
EMPLOYEE REQUESTING LEAVE FROM THE BANK**

I, hereby certify as the timekeeper/appointing authority for _____
that I have reviewed the leave and personnel records of the above referenced employee,
and affirm that the information contained on this form is true and accurate. The
requested leave does not exceed a total of 2080 hours of leave from the Leave Bank and
Employee-to-Employee Leave Donation Programs and when combined with all other
forms of paid leave does not exceed 16 months.

Signature of timekeeper/appointing authority

Date

**STATE EMPLOYEES' LEAVE BANK
MEDICAL REQUEST FORM**

1. DATE: ____/____/____

2. PATIENT'S NAME _____

3. DATE OF BIRTH: ____/____/____ SEX: _____

4. JOB CLASSIFICATION: _____

5. DIAGNOSIS: (Statement) _____

Provide International Classification of Diseases Code(s) (ICD-9):

6. Approximate date employee should return to:

a. Modified Activities/Duty ____/____/____ b. Full Activities/Duty ____/____/____

7. Summary of Treatment and anticipated procedures (attached additional sheets, if necessary): _____

8 Treatment according to Certified Procedure Terms (CPT) Code(s):

9. Please provide detailed information as to what aspect(s) of the position the employee is unable to perform. (Attach additional sheets, if necessary.)

10. Physician's Name: _____

(PRINTED OR TYPED)

(PHYSICIAN'S SIGNATURE)

(PHONE NUMBER)

Note: This document shall be treated as a confidential medical record and not placed in the employee's personnel file. Only those individuals with the need to know the information contained in this document, to evaluate and review this request will be given access to it. An employee who fails to appropriately safeguard the confidentiality of this document may be subject to disciplinary action, including termination, as well as any other liability imposed by law.

**ALL SECTIONS MUST BE COMPLETED IN ORDER FOR THE REQUEST TO
RECEIVE FULL CONSIDERATION.**

MS 401 (7/00)

REQUEST FOR LEAVE BANK

I, _____, hereby acknowledge that membership is not a guarantee that I will be granted leave from the State Employee's Leave Bank. I further acknowledge that any Leave Bank that is advanced to me, and subsequently denied is a debt that must be paid back out of my future earnings. I further understand that the minimum payback of Leave Bank Denials, will be one-half of the rate that sick and annual leave is earned bi-weekly. It is also understood and agreed that the Denied Leave Bank is a debt which will be enforceable until repaid, even after separation from State Service.

SIGNATURE: _____ DATE: _____



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Parris N. Glendening, Governor – Georges C. Benjamin, M.D., Secretary

TO: Whom it May Concern

FROM: _____
Employee's Name

SUBJECT: Release of Medical Records

Please release any medical records for the above named employee to the State of Maryland's Medical Director.

Employee's Signature/Social Security Number

Employee's Home Telephone Number

Physician's Name: _____

Physician's Address: _____

Toll Free 1-877-4MD-DHMH • TTY for Disabled – Maryland Relay Service 1-800-735-2258

Web Site: www.dhmh.state.md.us